Specialty Independent Review Organization

Notice of Independent Review Decision

Date notice sent to all parties: 8/17/2012

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

The item in dispute is the prospective medical necessity of lumbar selective epidural steroid injection at left L4 times two.

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:

The reviewer is a Medical Doctor who is board certified in Physical Medicine and Rehabilitation.

REVIEW OUTCOME:

Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

☒ Upheld (Agree)
☐ Overturned (Disagree)
☐ Partially Overturned (Agree in part/Disagree in part)

The reviewer agrees with the previous adverse determination regarding the prospective medical necessity of lumbar selective epidural steroid injection at left L4 times two.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

Records were received and reviewed from the following parties:
and MD

These records consist of the following (duplicate records are only listed from one source): Records reviewed from:

MD Letter – 8/1/12
Denial Letters – 6/5/12 & 7/6/12
Pre-authorization Denial Reports – 6/5/12 & 7/6/12
Summary Reports (x2) – undated

Pre-authorization Approval Reports – 4/11/12 & 5/3/12
LHL009 – 7/27/12
Requests for Authorization – 4/6/12, 5/2/12, 5/31/12, & 7/2/12
WC Patient Information – undated
Progress Note – 4/30/12
MD:
MRI Lumbar Spine Report – 9/21/11
MD:
Electrodiagnostic Study – 5/22/12
DO:
Office Notes – 10/19/11, 1/12/12

Lumbar Medical Branch Block Report – 2/17/12
Lumbar Selective Epidural Injection – 4/13/12
MD:
Progress Notes – 4/2/12, 4/30/12, 5/29/12

Records Reviewed from MD:
Progress Note – 1/30/12, 4/2/12, 5/29/12
Lumbar Selective Epidural Steroid Injection – 5/18/12

A copy of the ODG was not provided by the Carrier or URA for this review.

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male who was injured on xx/xx/xx when he was struck from behind by a player. The claimant was with another player when the injury occurred. The patient was assessed to have lumbar strain. He had undergone a prior lumbar fusion at L3-4. The patient has undergone physical therapy, oral medications and steroid injections. MRI of the lumbar spine dated 09/21/2011 showed bilateral L3-4 pedicular screws and intervertebral disc spacer. There was borderline to mild L3-4 foraminal stenosis which could compromise the exiting left L3 nerve root; there were bilateral L3-4 and L4-5 facet degenerative changes. Evaluation on 05/29/12 showed more pain standing than sitting and the least pain while lying down. The patient complained of referred pain to the left outer thigh which stopped above the knee. Claimant stated that bilateral L4-5 medial branch blocks performed in 02/2012 gave no immediate or subsequent relief. The claimant reported the L3 selective ESI in 04/2012 gave 100% relief for only one hour with relapse to baseline. L4 ESI done in 05/2012 gave 100% relief for four days and 50% relief at follow up visit. The physical examination of the lumbar spine revealed tenderness over the left mid-lumbar facets, painful decreased extension and bilateral lateral flexion, and normal neurological sensory and motor strength tests. Straight leg raise was noted to be negative.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS, AND CONCLUSIONS USED TO SUPPORT THE DECISION:

ODG Criteria for the use of Epidural steroid injections:
Note: The purpose of ESI is to reduce pain and inflammation, thereby facilitating progress in more active treatment programs, reduction of medication use and avoiding surgery, but this treatment alone offers no significant long-term functional benefit.

1. Radiculopathy must be documented. Objective findings on examination need to be present. Radiculopathy must be corroborated by imaging studies and/or electrodiagnostic testing.
2. Initially unresponsive to conservative treatment (exercises, physical methods, NSAIDs and muscle relaxants).
3. Infections should be performed using fluoroscopy (live x-ray) and injection of contrast for guidance.
4. Diagnostic Phase: At the time of the initial use of an ESI (formally referred to the "diagnostic phase "as initial injections indicate whether success will be obtained with this treatment intervention), a maximum of one to two injections should be performed. A repeat block is not recommended if there is inadequate response to the first block.
5. No more than two nerve root levels should be injected using transforaminal blocks.
6. No more than one interlaminar level should be injected at on session.
7. Therapeutic phase: If after the initial block/ blocks are given (see "Diagnostic Phase" above) and found to produce pain relief of at least 50-70 percent pain relief for at least 6-8 weeks, additional blocks may be supported. This is generally referred to as the "therapeutic phase". Indications for repeat blocks include acute exacerbation of pain, or new onset of radicular symptoms. The general consensus recommendation is for no more than 4 blocks per region per year. (CMS,2004)(Boswell, 2007)
8. Repeat injections should be based on continued objective documented pain relief, decreased need for pain medications, and functional response

The patient is a male who sustained lumbar strain. The claimant had several ESIs without significant relief. The request is for L4 ESIs times two. Per ODG guidelines, there must be documented radiculopathy as well as failed response to conservative therapy. In this case, based on the negative EMG, there is no documented radiculopathy. Additionally, there is no documentation regarding response to conservative treatment including exercises and response to medications. As such, this request is not medically necessary.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

- ☐ **ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE**
- ☐ **AHCPR- AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES**
- ☐ **DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES**
- ☐ **EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN**
- ☐ **INTERQUAL CRITERIA**
- ☒ **MEDICAL JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS**
- ☐ **MERCY CENTER CONSENSUS CONFERENCE GUIDELINES**
- ☐ **MILLIMAN CARE GUIDELINES**
- ☒ **ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**
- ☐ **PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR**
- ☐ **TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS**
- ☐ **TEXAS TACADA GUIDELINES**
- ☐ **TMF SCREENING CRITERIA MANUAL**
- ☐ **PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)**
- ☐ **OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)**